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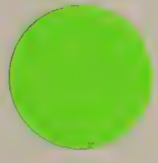

# OPTIONAL PAYMENT RATES FOR PHYSICIANS:

## An Analysis of Section 402 of H.R. 3626

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

November 18, 1991

Philip Lee, M.D.
Chairman
Physician Payment Review Commission
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Suite 510
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Dear Dr. Lee:

As you know, a successful cost containment program will be a critical component of health care reform.

On October 24, 1991, I introduced H.R. 3626, the "Health Insurance Reform and Cost Control Act of 1991."

Section 402 of H.R. 3626 would require the Secretary of the Department of Health and Human Services to establish optional rates for health services. These rates would be based on Medicare methodologies, including the resource-based relative value scale (RB RVS) for physician services. Insurers and other payers could elect to pay providers based on these rates, and providers would be required to accept these rates as payment in full.

I am writing to request the assistance of the Physician Payment Review Commission (PPRC) in the design and analysis of these optional payment rates for physicians.

Specifically, I am requesting that PPRC consider this proposal and provide the Committee with the results of the study.

This analysis should:

* Indicate the steps needed to ensure an orderly implementation of these rates, including the data required and the most effective administrative process; and

* Review the impact of national payment limits on physicians and other professionals.

To be most useful, the report of this study should be submitted to the Committee by March 15, 1992.

If you have any questions regarding this request, please contact James Reuter of the Committee staff at 225-7785.

Sincerely yours,

Dan Rostenkowski
Chairman

# EXECUTIVE SUMMARY

The Chairman of the Committee on Ways and Means requested the Commission to analyze Section 402 of H.R. 3626, the "Health Insurance Reform and Cost Control Act of 1991," which would establish optional payment rates for private purchasers based on the Medicare Fee Schedule and establish charge limits for services purchased under such rates that are the same as the limits under the Medicare program. He specifically called for study of the steps needed to ensure an orderly implementation of such rates and the impact on physicians.

The report begins by identifying aspects of the provision that require clarification. For the purposes of this report, the Commission has assumed that private purchasers could either opt to use Medicare rates for all covered services and practitioners or not at all, but that an insurer could decide not to use the rates for HMO and PPO plans while opting to use them for traditional plans. It assumes that private insurers could choose to pay up to the Medicare charge limits, like supplemental coverage for Medicare. Finally, it assumed that the PAR program would not apply to nonMedicare patients.

Changes in payment methods on the part of private purchasers would parallel what many are already pursuing to incorporate elements of the Medicare Fee Schedule into their systems. With CPT coding now almost universal, the only significant change would be adoption of Medicare payment policies, such as global surgical payment, that are related to the calibration of relative values.

Medicare's resource-based relative value scale was originally developed for a general population, so most relative values will be applicable to nonelderly populations. The refinements to relative values needed for Medicare payment (see the Commission's forthcoming *Annual Report to Congress 1992*) will take on increased importance as a larger portion of physician revenues are affected. Significant attention needs to be devoted to refining relative values for obstetrical services (which are distorted due to the practice expense and malpractice expense relative values) and pediatric services. The latter will require significant work on the part of the commission described in Section 401 of the bill.

While the bill specifies using the Medicare conversion factor for optional payment rates, consideration needs to be given to alternatives. There is little basis to conclude that Medicare rates would be the appropriate level if applied to all payers. Alternatives would include a single rate for all payers that could be different from the current Medicare rate or a two-tiered system in which the optional rates were higher than Medicare rates. The latter could be used at least as a transitional mechanism.

Administrative tasks that would be the responsibility of the federal government would include disseminating information on Medicare rates and payment policies, enforcing charge limits, and monoitoring expenditures and balance billing. Enforcement of charge limits could parallel policies used in Medicare, except that private purchasers would conduct the screening of claims and notification of physicians, and HCFA would conduct or contract for the determinations of whether physicians have "knowingly and willfully" violated the charge limits. Monitoring would require some reporting of data by private purchasers to the federal government along the lines that are discussed in Chapter 10 of the Commission's 1992 Annual Report.

Since Medicare rates are substantially lower than rates paid by private purchasers, the proposal would reduce revenues received by physicians and payments by private purchasers and patients. Data on rates paid by private purchasers are very limited, but do provide a basis for rough estimates. The Commission projects that in 1994, when this proposal would take effect, Medicare payment rates for physicians' services will be 35 percent less than private insurers' payment rates. If most of the payers using the optional rates decide to pay up to the Medicare charge limits, payments to physicians would decline by 25 percent, reducing physician revenues from all payers by approximately 15 percent. Increases in volume in response to payment reductions could diminish the impact on physicians. Since Medicare rates will be based on a resource-based fee schedule, the impact on physicians will vary substantially by specialty and by geographic location.

Insurers and patients would pay roughly 25 percent less. Much of the reduction in premiums would benefit employers and employees, with the reduction in employer costs going to consumers, shareholders, and employees. Competitive relationships within the health insurance industry would be affected, with those carriers that have been most successful in paying discounted rates to physicians (Blue Cross-Blue Shield plans with participating physician programs and Blue plans and commercial insurers with the most extensive HMO and PPO activity) losing some of their cost advantage. The advantages from success in managing care would not be affected.

# OPTIONAL PAYMENT RATES FOR PHYSICIANS: An Analysis of Section 402 of H.R. 3626

In a letter dated November 18, 1991, the Chairman of the Ways and Means Committee requested an analysis by the Commission of Section 402 of H.R. 3626, the "Health Insurance Reform and Cost Control Act of 1991."[1] This section would permit private payers to purchase physicians' services at rates paid by the Medicare program (under the Medicare Fee Schedule) and limit physician charges to those applying to Medicare beneficiaries. The analysis is to:

- indicate the steps needed to ensure an orderly implementation of these rates, including the data required and the most effective administrative processes; and

- review the impact of national payment limits on physicians and other professionals.

The report begins with a description of the proposal, including a discussion of aspects that require clarification. Then it discusses what would be involved in implementation, both on the part of the private payers and on the part of the federal government. The final section reports on simulations of the impact of this proposal on physicians, payers, and patients.

## DESCRIPTION OF THE PROPOSAL

Section 402 would require the Secretary of Health and Human Services to establish payment rates for physicians' services that can be used by private purchasers (either health insurance plans or individuals) if they so desire. Section 402 further specifies that:

- these optional physician payment rates will be based on the Medicare Fee Schedule with appropriate adjustment for differences in the scope of coverage and population served by the Medicare program versus other payers;

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[1] Readers should not confuse this proposal with Mr. Rostenkowski's comprehensive health care proposal, the "Health Insurance Coverage and Cost Containment Act of 1991" (H.R. 3205).

- a maximum charge for each service is to be established that is to be the same as that provided for under the Medicare program.[2]

Today, private payers can set physician payment rates independently. But unless an agreement has been reached with the physician, the patient is responsible for the difference between that rate and the amount charged. Thus, the key provision of Section 402 that is the setting of maximum charges (limits on balance billing).

While the Medicare Volume Performance Standards (VPS) are not explicitly referred to in the proposal, they would play a role. Since Medicare payment rates are updated through the VPS, and private purchasers would be given the option to pay at Medicare rates and have physicians' charges limited to Medicare charges, the VPS would determine updates in the rates available to private purchasers and the accompanying charge limits.

Future consideration might be given to a broadening of the VPS to include expenditures on behalf of private patients whose purchasers elect this option. But this would allow Medicare payment rates to be influenced by changes in physicians' services provided to privately insured patients. Alternatively, a separate VPS could be created to update the optional rates. In this case, however, the optional rates would not necessarily be the same as Medicare rates.

Some aspects of the bill are not clear. It does not stipulate whether a payer that elects to use the optional payment rates must employ the optional rates universally or whether it may employ the rates selectively. There are several ways in which an insurance company, or other payer, could implement the optional payment rates on a selective basis. Specifically, they might use them:

- for some, but not all of their insurance offerings (e.g. they might elect to use the optional payment rates in the indemnity plans that they offer, but not in their PPO's or HMO's);

- in some regions of the country, but not in others;

- for some physicians' services, but not all such services; or

- for some, but not all providers, within a given region.

Permitting an insurer to use the optional rates only for its traditional plans but not for HMOs and PPOs might be important to maintaining the viability of these alternative plans.

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[2] By 1993, the maximum charge permitted under Medicare will be 115 percent of the allowed payment to nonparticipating physicians.

In the case of HMOs, insurers often use mechanisms other than fee for service to pay physicians, and it would be difficult and expensive to determine whether these payment arrangements are consistent with Medicare rates. In the case of fee-for-service payments, advocates of all-payer rate setting disagree as to how much flexibility individual payers should have to pay less than the established rates. While selectivity by insurance plan would introduce some complexity, this would be limited because health plans that chose not to use Medicare rates would likely be those in which contracting between the plan and physicians is already in place.

Different considerations underlie whether private payers should be permitted to select when to use Medicare rates by geographic area, by service, or by provider. Permitting flexibility on these dimensions risks sacrificing the goal of broadening the pattern of payment reform to private payers, one of the major considerations in this proposal. If, for example, a private payer decided to lower payments for surgery to Medicare rates, but not to increase payments for evaluation and management services, this would result in relative payments that differ from the Medicare relative value scale and undermine the principles behind physician payment reform. Many would regard giving private insurers the ability to pick and choose when to employ Medicare payments and charge limits as unnecessary and unfair.

Given the structure of the health insurance industry, however, a decision to clarify the proposal to preclude insurers from using Medicare rates in some geographic localities but not others would not necessarily be effective. With Blue Cross-Blue Shield plans covering only a state or substate area, they would de facto have the ability to decide on a state-by-state basis whether to use the optional payment rates. National commercial insurers would not have such flexibility, but might find ways around such a restriction through formation of subsidiaries, however.

Another issue to clarify is whether private payers electing to use Medicare rates could pay more than Medicare pays, up to the limiting charge. Of course, Medicare beneficiaries can and do arrange for an insurer to pay balance bills (as well as deductibles and coinsurance) on their behalf by purchasing Medigap coverage. To restrict a private insurer from paying up to the charge limits would impose a restriction on those covered by private insurance that does not apply to Medicare beneficiaries.

It is likely that most private payers would pay up to the charge limits (or, more precisely, pay 80 percent of the amount once the deductible has been met). Much private insurance involves either contracts with physicians that preclude balance billing or reasonable charge screens that are set high enough so that most physicians' charges are approved. With charge limits below existing screens or contracted amounts, insurers are likely to continue not having beneficiaries face balance bills.

The role played by Medicare's rules concerning participating (PAR) physicians will have to be considered. Since nonparticipating physicians are paid at 95 percent of the fee schedule, would the payment by private payers vary according to whether the physician had signed a Medicare PAR agreement? Would the PAR agreement be broadened to include patients whose insurer elects to use the Medicare rates? Could physicians sign separate PAR agreements with private payers? Broadening PAR agreements to nonMedicare patients would probably constrain balance billing for this population, but some of this could come at the expense of higher balance billing for Medicare beneficiaries, as some physicians drop out of the PAR program in response to its broader applicability.

In referring to the Medicare payment system, the proposal mentions a resource-based relative value scale but makes no mention of practice expense relative values, malpractice expense relative values, the geographic adjustment factor (GAF), or the conversion factor. This report assumes that the payment rates are based on all aspects of the Medicare Fee Schedule.

## IMPLEMENTATION OF SECTION 402

Since most private insurers and patients pay physicians in a manner similar to Medicare -- albeit at rates that are often quite different -- their use of optional Medicare rates would involve only limited change. In contrast to Medicare's Prospective Payment System (PPS) for hospitals, which changed the unit of payment from the individual service provided by the hospital to the case (DRG), the Medicare Fee Schedule continues the use of fee for service. Thus, a private payer contemplating the option to use Medicare rates would not face a complex restructuring of its fee-for-service payment mechanism. With most physician payment based on fee for service, adjustments in payment policies needed to make Medicare fee levels equivalent for private payers would not be extensive.

This section reviews the technical work that would be necessary to implement the provisions of Section 402. It covers adjustments that would be faced by private payers choosing to use Medicare rates and tasks on the part of the federal government to provide information to private payers, physicians, and patients and to enforce the limits on charges.

### Adjustments by Private Payers

Changes in payment methods on the part of private payers would parallel what many are currently pursuing in the course of incorporating elements of the Medicare Fee Schedule into their payment mechanisms. Discussions with insurers have indicated strong interest in incorporating Medicare's relative value scale into their own payment systems. Many insurers are seeking to move away from "reasonable charge" payment systems because of recent sharp increases in submitted charge rates by physicians that the insurers feel are

in response to payment cuts under Medicare. The changes are evolutionary, however, with elements of reasonable charges retained.

Many Blue Cross and Blue Shield Plans have already begun to reform their method of physician payment in response to Medicare's relative value scale. Many differentiate between overvalued and undervalued services in their annual updates. Others are planning more extensive changes for 1993 or 1994. A few Plans will use the Medicare relative value scale and their own conversion factor as an additional screen in their reasonable charge systems. Reductions in payments for procedures will be used to raise payments for evaluation and management services. A few others are contemplating substituting such a screen for their prevailing charge screens and making a transition over a 3-5 year period from a reasonable charge based system to a fee schedule. These Plans expect to depart from Medicare relative values in order to maintain adequate participation rates throughout their markets. Some relative values will be adjusted when Plans' payment policies differ from Medicare's.

The use of optional payment rates would represent a dramatic change in the relationship between insurers, especially Blue Cross-Blue Shield plans and physicians. A long history of contracting (participating physician programs) would be replaced by insurers using externally-determined payment rates, though aspects of the contracts other than price might continue. The implications for competition within the insurance industry are discussed in the last section.

Private payers choosing to pay physicians according to the provisions of Section 402 would have to make some changes in their coding and payment policies so that they conform to Medicare's. All Blue Cross-Blue Shield plans and roughly 85 percent of commercial insurers already use CPT-4 coding, which is used by Medicare for all physicians' services. Indeed, both the Blue Cross-Blue Shield Association and the Health Insurance Association of America have representatives on the CPT Editorial Panel. Those payers not using CPT-4 would have to convert to it. While this would be a substantial undertaking, many would regard the shift as a desirable one that would reduce "hassle" for physicians and patients.

In the case of new services that do not yet have a CPT code, Medicare carriers will in the interim assign a local code and establish a relative value. Private payers could make use of such data as long as a mechanism was established to obtain the code and relative value from the Medicare carrier or from HCFA.

A more substantial task would involve conforming payment policies to those of Medicare. Payment policies include rules such as what services before and after surgery are to be included in the global fee. Until the implementation of the Medicare Fee Schedule began this year, each Medicare carrier developed its own policies. But implementation of a national relative value scale led HCFA to develop standard payment policies. Otherwise,

the physicians in different parts of the country would face different implicit relative values despite a national relative value scale.

HCFA's efforts to develop standard payment policies were extensive. It drew on PPRC's work on global surgical definitions for major surgery and received very extensive comments from various segments of the medical profession. The policies reflect the mainstream of existing practices by Medicare carriers. HCFA has also developed policies for global payment for minor surgeries and nonincisional procedures, such as endoscopies, and policies concerning how to adjust payment when various code modifiers are present.

In order to use Medicare payment rates, private payers would have to revise their payment policies to follow those of Medicare. For example, a private payer might currently include 30 days of postoperative care in its global surgical definition but would have to change this to the 90 day period now used by Medicare.

Many observers expect private payers to begin adopting the new Medicare payment policies in any case. In the past insurers have adopted many Medicare policies, perhaps out of a desire to conform to a standard. In addition, those insurers planning to incorporate elements of Medicare's relative value scale into their own payment system recognize the connection between the calibration of the relative values and payment policies. Thus, many private payers will have few steps to take concerning coding and payment policies if they choose to avail themselves of the provisions of Section 402.

Not all of Medicare's payment policies would have to be adopted by private payers. Some are not intertwined with the calibration of relative values. For example, private payers would not have to adopt the Medicare policy on coverage of transplants, since that policy does not affect the relative value scale. Nor would they have to stop paying for electrocardiograms that are performed in conjunction with a visit.[3] Private payers could also maintain their own rules concerning payment for concurrent care. Undoubtedly, many decisions on whether payment policies would have to conform would require judgments by HCFA.

The promotion of uniform coding and payment policies could provide substantial benefits for physicians and patients by reducing confusion and administrative costs. By approaching this through a policy of optional payment rates, the government would be using incentives rather than regulation to further this public policy goal. By leaving the option open for some payers to continue current practices, the government might be less constrained in requiring substantial uniformity. Competitive forces would motivate private insurers to make the changes.

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[3] Since HCFA increased relative values for certain visit codes to reflect frequencies of EKGs, visit relative values used by private payers that do not follow Medicare's EKG policy would have to differ from those used by Medicare by those precise adjustments.

**Modifications to the Relative Value Scale**

The physician work values used in the Medicare Fee Schedule were developed to apply to physicians' services used by a general population. In the study conducted by William Hsiao and his colleagues at Harvard University, the vignettes that were rated for physician work covered persons of all ages rather than only those aged 65 and over. For this reason, the relative work values would in most cases not require modification to apply to a privately insured population.

The orientation of the Hsiao study towards a general population has in fact presented some problems in development of the Medicare Fee Schedule. Some services involve additional physician time when the patient is elderly. In previous work, the Commission has documented additional inpatient postoperative visits for elderly patients for certain major surgeries. The payment, however, will not reflect this since a fixed sum covers 90 days of postoperative care. Other services, such as interpretation of an X-ray, do not involve more time when the patient is elderly. The new visit codes, which include typical encounter times, provide some opportunity for physicians to bill for higher levels of service when elderly patients require more physician time.[4] The Commission has recommended the development of a *Medicare adjuster* to be applied to a list of defined services in order to make the relative values appropriate for the Medicare population.

Despite the Hsiao study's orientation to the general population, relative values for some services need attention if the Medicare relative value scale is to be applied equitably by other payers. Modifications for obstetrical and pediatric services are the most prominent needs.

**Obstetrical Services.** Medicare does pay for a small number of deliveries per year by women eligible for Medicare on the basis of either receipt of disability insurance payments or end stage renal disease. The Hsiao study provides an estimate for physician work.

However, Medicare historical charges, which are the basis for the practice expense and malpractice expense relative values, appear to be distorted. In 1989, surgical services had ratios of Medicare allowed charges to submitted charges that averaged 70 percent. However, allowed charges for vaginal deliveries and cesarian deliveries were only 49 percent and 59 percent of submitted charges, respectively. This difference may reflect the interaction of rapid increases in fees by obstetricians in response to rising malpractice premiums and the Medicare Economic Index constraining increases in Medicare prevailing charges from 1973 levels.

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[4] As discussed in Chapter 2 of the Commission's 1992 Annual Report to Congress, further refinements are needed in these new codes. A problem of particular relevance to the elderly is the inability to bill for higher levels of service when the patient presents with multiple problems or to account for additional time with patients with special needs.

If Medicare charges for obstetrical services relative to charges for other surgical services paralleled the relationship in the private sector, practice and malpractice expense relative values under the Medicare Fee Schedule would be 43 percent higher for vaginal deliveries and 19 percent higher for cesarian deliveries. If obstetrical services were more important in Medicare, this apparent distortion would likely have gotten significant attention.

Medicare's use of historical charges as a basis for malpractice expense relative values undervalues obstetrical services in an additional way. The malpractice relative value is based on survey data on the percent of revenues going to malpractice premiums for obstetrician-gynecologists and family physicians (specialty weights based on proportions of Medicare deliveries). In effect, this spreads malpractice costs evenly over all services provided by physicians in these specialties. But obstetrical services account for disproportionate amounts of malpractice premiums for these specialties. A risk-adjusted approach to relative values, such as the one the Commission has been working on, would raise malpractice relative values for these services and lower them for other services provided by these specialties.

**Pediatric Services.** Some of the Medicare relative values will likely need to be adjusted when applied to services delivered to children. For procedures, at least three factors contribute to differences in work. First, CPT codes may not distinguish a procedure performed on a child for a particular indication from an essentially different procedure performed on an adult for the same problem.[5] For example, treatment of a bimalleolar ankle fracture in growing children may require a different type of internal fixation, with different needs for postoperative monitoring and different potential complications. Nevertheless, it is combined with other treatments of bimalleolar ankle fractures on adults in a single CPT code.

Second, the work involved in performing a number of procedures on a young child is substantially higher than that for the adult patients usually described in the vignettes in the Hsiao study. The anatomic and physiological differences between children and adults often pose greater technical difficulty for the physician and make the procedure riskier. For example, a percutaneous renal biopsy of a child is more difficult simply because the target kidney is smaller.

Finally, children may be less cooperative as patients. For example, children often have difficulty obeying the instructions required to perform spirometry. Consequently, the test must often be repeated many times, necessitating more work on the physician's part.

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[5] There are a few codes in the CPT (e.g., tonsillectomy) for which separate codes are provided based on the age of the patient.

On the other hand, physician work may be less for some services for children. Recovery from major surgery, for example, is often faster in children and requires fewer postoperative visits.

Evaluation and management (EM) services, which make up at least 50 percent of Medicaid pediatric expenditures, raise at least two issues. First, preventive services such as well-baby visits are not covered under Medicare and consequently have no relative work values. Well-baby visits, however, were surveyed by Hsiao and do have Hsiao work values. Second, EM services provided to certain children may require more work than the same services furnished to adults. An intermediate office visit involving an infant, for instance, may entail more parental counseling and more telephone support -- both before and afterwards -- than an intermediate visit involving an adult. EM services to children were, however, surveyed in the Hsiao study, thereby creating a potential basis for setting relative values.

Developing *pediatric adjusters* may be a more extensive task than developing a Medicare adjuster. Differences in work between children and adults may be larger than those between elderly and nonelderly adults. Application of a uniform percentage adjuster to a range of services (as opposed to adjusters specific to each service code) may be less appropriate for children than for the elderly population.

Developing pediatric adjusters will require efforts on the part of HCFA or the commission that would be created under Section 401 of this bill. It is not clear at this time whether this will require additional research using techniques of magnitude estimation, or whether an expanded refinement process involving representatives of pediatrics along with the carrier medical directors and other specialties would be more effective. However, given the speed with which some Medicaid programs and private insurers are acting to incorporate relative values, it might be best to start with the expanded refinement process described above. Thereafter, research on questions that prove most difficult to resolve could be initiated.

Basing practice expense and malpractice expense relative values on historical charges also contributes to inaccuracies in relative values for pediatric services. These components of the relative value scale reflect both the charges and ratios of practice expenses to total revenues of specialties that provide these services to the Medicare population. To the degree that pediatricians have different ratios (or historical charges), the omission of pediatricians from the Medicare calculations will make the practice expense and malpractice expense components less accurate for them than for the physicians who treat Medicare patients.

Whether or not Section 402 is enacted, the federal government should play a leadership role in developing the refinements that are required to make the Medicare relative value scale applicable to populations covered by private insurers and Medicaid programs. It

would waste resources if numerous programs using resource-based relative values each hired their own consultants and developed their own parameters. In addition, having numerous payers independently develop modifications to the relative value scale could undermine physicians' acceptance of resource-based payment mechanisms.

The commission that would be created under Section 401 could develop the modifications in relative values most relevant to nonMedicare populations. It could draw various private purchasers, Medicaid programs, HCFA, and organizations representing physicians and consumers.

**Applicability of the Geographic Adjuster**

For the most part, Medicare's geographic adjustment factor (GAF) is equally applicable to private payers. The concept behind it -- an index of input prices faced by physicians -- is appropriate for private payers as well. Improving the data that are used to develop the GAF would take on even greater importance if a higher proportion of physician revenues were determined by it.

Locality boundaries may pose a problem. Medicare's 230 payment areas were designed by Medicare carriers and do not follow any common principle. As the Commission has pointed out and HCFA has acknowledged, Medicare locality boundaries could be improved upon. The Commission has recommended that with the exception of those states in which variation in input prices is the greatest, that payment areas be statewide.

Many private payers define localities for their payments differently than Medicare does. To pay according to Medicare rates, private payers would have to use Medicare localities. While such a change would not pose major obstacles, it provides an additional reason for Medicare to proceed to reform its locality boundaries.

**Setting the Conversion Factor for Private Payers**

Section 402 calls for HHS to establish payment rates based on Medicare rates, with "appropriate adjustment to reflect differences in the benefits and populations served". For physicians' services, such adjustments are likely to be limited. Under fee-for-service payment, the only adjustment associated with benefits covered would be the need to develop relative values for services that are not covered under Medicare but that are covered under some private insurance policies. Adjustments to take account of differences in populations served were discussed above.

The Congress might want to consider other factors that could be the basis for differences in rates. For example, under hospital payment, the bill calls for an adjustment to take into account the costs of providing care for which no payment or only partial payment of the applicable rate is made. Like hospitals, physicians provide some services at rates lower

than Medicare. On average, Medicaid rates are only 64 percent of Medicare rates. About 8 percent of physicians' services were uncompensated in 1989.[6]

A rate difference could be authorized so that rates for private payers exceed Medicare rates by a margin large enough to offset instances in which the payments are below Medicare. But the analogy with hospitals breaks down here. In hospitals, Medicare rates are tied to costs. Prospective rates began at levels paid under cost reimbursement and debates over annual updates have focused on cost increases. But Medicare physician payment rates were never tied to costs. Their origin was historical charges. With Medicare only one of many payers, annual adjustments in Medicare payment rates were able to be considered in light of not only cost increases experienced by physicians, but also competing demands on the federal budget and levels needed to assure beneficiary access to care.

As a result, current Medicare rates of payment to physicians are not necessarily the level that should be received from all payers. To the degree that federal policy determines the rates paid by others, consideration of physician incomes will have to be incorporated as well.

If the Congress should decide that Medicare payment rates are too low to be used by all other payers, it would have two options. First, it could choose a single all-payer level that is lower than current private rates but higher than current Medicare payments.[7] This would increase federal outlays. Second, it could establish a two-tiered system, with the current rate for Medicare and a higher optional rate for private payers.[8] It could either set the Medicare/private differential and leave decisions on whether to narrow it for the future or it could schedule a full or partial phasing out of the differential.

While these payment rate differentials would be smaller than what obtains today, some would object to such a policy as an endorsement of or legitimization of a pattern of payment differentials with public payers getting the lower rates. These issues might be more easily addressed in a context of overall health system reform, in which higher payments be Medicare and Medicaid could be considered along with lower payments by many private payers.

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[6] This is based on an estimate by the American Medical Association reported in CBO, 1991.

[7] Medicaid rates could also be increased as part of such a policy.

[8] If Medicaid payment rates were not changed, this would amount to a three-tiered system.

**Administration**

A number of administrative tasks would have to be conducted by the federal government. These include dissemination of information on Medicare rates and payment policies, enforcing charge limits, and monitoring expenditures and balance billing.

Information on Medicare payment rates and charge limits would have to be disseminated to physicians, insurers, and consumers. Most physicians already are informed about Medicare rates through their Medicare carrier. Physicians who treat only nonMedicare patients (for example, pediatricians) could be informed by private insurers, Medicaid programs, and professional organizations. Insurers and third party administrators could be informed through the *Federal Register*. The most practical way to inform consumers would be by HCFA providing information to the media and supplying additional information to those individuals who request it.

Private purchasers would need to inform physicians and patients that they have elected to pay at Medicare rates. With the exception of large plans, it would not be practical for each insurer to inform each physician in advance of possible services provided to their beneficiaries. Insurers could inform the physician upon receipt of a claim. If the physician charged more than the limit because of uncertainty as to whether the purchaser had elected to use Medicare rates, the insurer could inform the physician that a refund was due the patient. This would be an awkward arrangement, with physicians not knowing what they will receive for treating each patient. If most private insurers use the optional rates, however, the awkwardness would be limited.

Enforcement of the charge limits could parallel policies used by Medicare. In its 1992 Annual Report to Congress, the Commission will recommend a number of changes in the administration of Medicare charge limits (PPRC 1992, Chapter 3). These include prepayment screening by carriers of all claims, notification of beneficiaries and physicians in each instance where the charge limit is violated, and clarification that beneficiaries are not liable for charges above the legal limit and that physicians must refund such amounts.

One difference from Medicare would involve activities that Medicare carriers perform for HCFA. Presumably, the private payers would conduct the prepayment screening to detect violations of charge limits and bring violations to the attention of the physician and beneficiary. If violations could not be resolved, the private payer would have to refer the matter to HCFA, which would make a determination of whether physicians have "knowingly and willfully" violated the charge limits and whether civil monetary penalties should be assessed.

### Transition

While Section 402 does not specify a transition, the substantial changes in payments that it would bring about (see below) will lead many to consider how to spread the impact out over a number of years. Another advantage of a transition is its allowing of time for the federal government to obtain more extensive data on physician payment by private insurers.

Some phasing would come automatically from the time that it would take some private insurers to prepare to participate. Many have contracts with physicians that include more than payment rates and these would take time to negotiate. Some insurers would have to make claims processing systems changes to facilitate payment on the basis of a fee schedule. Phasing would also come from the fact that the transition to the Medicare Fee Schedule will be continuing until 1996.

One way in which the federal government could phase in such a policy would be to start with optional payment rates that are higher than Medicare. For example, the program could begin with optional payment rates and charge limits 20 percent above Medicare's and then lower the rates and limits over time.

## IMPACT ON PHYSICIANS, PRIVATE PAYERS, AND PATIENTS

Since Medicare payment rates are now substantially below those of private payers on average, Section 402 would reduce revenues of physicians significantly. This reduction would benefit those paying insurance premiums (and underwriting the costs of self-insured plans) -- mostly employers and employees. Federal revenues would increase to the degree that employers had higher profits and employees received more compensation that was taxable.

### Data for Analysis

Precise estimates of the magnitudes of these impacts are not possible because data on payments to physicians by private insurers and patients are so limited. Few, if any, insurers maintain databases like HCFA's BMAD or National Claims History files and much of what data exists is kept confidential for competitive reasons. The only information on what patients pay is from an occasional question on physician surveys.[9]

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[9] See Chapter 10 of the Commission's 1992 Annual Report to Congress (PPRC 1992) for a discussion of the instances in which the absence of an all-patient database limits many opportunities to improve quality and contain costs.

Nevertheless, the Commission is fortunate to have access to and experience using two reliable data bases that permit comparison of Medicare payment rates with those of private payers. For a number of years, the Blue Cross and Blue Shield Association has worked with the Commission by providing data that permit comparison of Medicare rates for high-volume services with rates paid by many of the Plans.[10] Data for 1988, 1989, and 1990 have been analyzed. In addition, data for 1989 have been purchased from Medstat Inc., which cover a self-selected sample of large employers, many of which are self insured.[11] Data on the composition of physician revenue by type of payer come from annual physician surveys by the American Medical Association and *Medical Economics*. Few data are available on balance billing paid by privately insured patients.

Projecting changes in the relationship between Medicare and private insurer payment rates from 1989 or 1990 to 1994, when the provisions of Section 402 would be effective is difficult because of both the changes taking place in private insurance, with more discounting, and the extensive changes in Medicare payment rates and policies. For Medicare, substantial budget cuts took effect in 1990 and 1991 and implementation of the Medicare Fee Schedule, which began in 1992, was accompanied by a substantial baseline adjustment.

While simulations with the Medicare database provide relatively precise estimates of changes in Medicare payment rates, the sharp change in Medicare makes it more difficult to project what happened to rates paid by private insurers over that period. These changes may both stimulate increased use of preferred provider arrangements to obtain discounts and lead to an acceleration in the rate of increase of submitted charges. Private insurers have indicated that payment rates in reasonable charge systems have been increasing rapidly as a result of charge increases in response to declining payments from Medicare.

**Payment Rate Differences**

The critical estimate for the analysis of the impact of this provision on physicians, insurers, and patients is the difference in payment rates between Medicare and private insurers. Constructing this estimate begins with comparisons of payment rates between Medicare, on the one hand, and Blue Cross-Blue Shield and Medstat, on the other. For 1989, using the Medicare service mix, a composite ratio of 71 percent was used.

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[10] The rates paid by Blue Cross and Blue Shield plans include both traditional arrangements and preferred provider arrangements. Individual plans cannot be identified.

[11] Medstat data include the experience of both commercial and Blue Cross-Blue Shield insurers. The extensive data maintained by the Health Insurance Association of America (HIAA) could not be used because information is collected only on submitted charges, not approved charges or the amounts paid. Previous work by the Commission suggests that HIAA data on submitted charges is consistent with that from Medicare.

To project changes in this ratio from 1989 to 1994, a number of factors were taken into account. First, the effects of Medicare payment changes, including annual updates, payment changes from 1989 and 1990 budget legislation, and the baseline adjustment for the fee schedule are simulated. Second, the implications of private payers switching from their current structure of payment to Medicare relative values is simulated. Not only does the services mix of the privately insured population differ from the Medicare population (more obstetrical care, fewer hospital visits), but the ratio of Medicare payment rates to private payment rates differs by service. Using the privately insured service mix reduces the magnitude of the difference between Medicare and private payment rates. Third, private insurer payment rates are assumed to increase at about 4 percent per year between 1989 and 1992 and at one percentage point per year more than the Medicare update thereafter.[12]

The net impact is a projection that Medicare payment rates for the service mix covered by private insurers will be 65 percent of what private insurers will be paying in 1994.

**Impact on Physicians**

In order to calculate the impact on physicians some additional issues must be addressed. All private payers are assumed to use the option of paying at Medicare rates. With the 35 percent payment differential that has been estimated, use of Medicare rates would indeed be very attractive to most private payers. Thus, this polar assumption might be close to what would transpire. In any case, the estimates can be viewed as specifying the maximum possible impact.[13]

No projection is made concerning changes in the volume of services provided by physicians in response to lower per service revenues from private payers. With a change of this magnitude, it is likely that the volume of services will change, but it is difficult to make an accurate projection. If the result is a net increase in volume, this would mitigate to some extent the magnitude of the revenue reduction to physicians and the savings to private payers. Medicare could experience some an increase in volume as Medicare patients became relatively more attractive to physicians. Any effects on Medicare volume would affect prices though the Volume Performance Standard mechanism. The resulting adjustment of Medicare fee updates would affect prices paid by private insurers as well.

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[12] This is substantially less than the rate of increase in physicians' fees, as measured in the Consumer Price Index, which has been increasing at about 7 percent per year.

[13] It should be noted that if private payers were permitted to use a payment rate that was a certain percentage above the Medicare rate, a smaller proportion of payers would opt to use them. This introduces an important nonlinearity in estimating the impact on physicians. Thus, if the optional rate was half way between the Medicare rate and the average private rate, the impact would be different from one half of using the Medicare rate. Fewer private insurers would use the optional rates but those that did would have higher than average current payment rates.

The impact on physicians is discussed in terms of revenue rather than income. Translation of the impacts on revenues to impacts on incomes would depend on the degree to which physicians succeed in cutting practice expense in response to lower revenues.

The estimates of the impact of this policy are limited by the lack of information concerning the extent of balance bills paid by those covered by private insurance.[14] Some observers feel that balance billing is not extensive. They project that most private insurers, which have traditionally used high payment screens or contracts to limit balance billing, will continue to do so by paying up to the Medicare charge limit. If this is accurate and physicians charge at the Medicare limits (115 percent of the Medicare Fee Schedule), then private insurers will pay physicians 75 percent of what they paid before (25 percent less). If private payers using Medicare rates/charge limits account for 60 percent of physicians' revenues, then physician revenues would decline by 15 percent.

To the degree that current balance billing of privately insured patients is higher, the loss of revenue to physicians might be somewhat larger. In that case, current levels of balance billing might be higher than that permitted under Medicare charge limits. To the degree that volume increased in response to lower fees, the effective reduction in revenues would not be as large.

The impact on physicians would vary by specialty and geographic area. These variations generally would follow the impact of the Medicare Fee Schedule (see PPRC 1992, Chapter 2). While pre-fee schedule payment differences between Medicare and private insurers do vary by specialty and by geographic area, overall the differences do not follow a strong pattern.[15]

The strong pattern of redistribution from the Medicare Fee Schedule implies that the impact of Section 402 would differ substantially by category of physician. For example, upon completion of the transition, cardiologists' Medicare payment rates would decline by 17 percent relative to the average physician, so the reduction in payment rates by private insurers might be 38 percent compared to 25 percent for the average physician. Physicians practicing in the geographic localities in which payment rates will decline most under the fee schedule would also feel a greater impact. In those areas in which the declines are greatest, Medicare payment rates will decline 15 or 20 percent in relation to the average physician. Combining specialty and geographic area suggests that the reduction in payment rates by private insurers could range from virtually none for family physicians in

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[14] While some data indicate differences between submitted and allowed charges, they do not indicate how much of that difference patients are asked to pay (and of that, how much they actually do pay). For example, many physicians sign contracts with Blue Cross-Blue Shield plans in which they agree to accept the plan's approved charge as payment in full.

[15] Further analysis is being pursued on patterns of variation by specialty and geographic area.

some rural areas to more than 50 percent for physicians in certain procedure-oriented specialties that practice in those areas experiencing the largest declines under Medicare payment reform.

The magnitude of these impacts on physicians suggests that careful consideration be given to modifications in this policy. One option would set the optional rates and charge limits higher than Medicare levels. If these were a fixed percentage above Medicare levels, the principles of resource-based payment would be carried over to private insurers without as large an impact on some physicians' revenues. While this would officially recognize payment differentials between Medicare and private insurers, it would reduce them. Another option would be to approach optional payment rates as part of a broader reform in which physicians would get higher payments from Medicaid patients, patients who are currently uninsured, or even Medicare patients.

In considering these analyses of private insurers using Medicare rates, an important point to bear in mind is that the overall level of Medicare payment rates is not necessarily the "right" level. Unlike hospital payment, Medicare physician payment was never tied to a measure of costs. With Medicare only one of many payers, annual adjustments in Medicare payment rates could be considered in light of competing demands on the federal budget rather than what is the "right" level of physician income. An all-payer system of physician payment should not begin with an assumption that Medicare rates are the right ones, but will need to make such judgments.

**Impact on Insurers, Patients, and Others**

The reduction in payments received by physicians would mean that those who pay insurance premiums and patients that pay cost sharing would pay less for physicians' services. In instances where insurers are at risk, they might experience a temporary windfall if the reduction in claims preceded adjustment in premiums to reflect this. Once reflected in premiums, lower claims costs would benefit employers, employees, and others who pay premiums. Gains to employers would be reflected in lower product prices, higher profits, and higher wages for employees.[16]

Important competitive changes in the insurance market might result. Those insurers that currently have an advantage in being able to purchase physicians' services for less would find that advantage diminished. The data presented here suggest that Blue Cross-Blue Shield plans have had an advantage over commercial insurers in the purchase of physicians' services. This proposal might erode that advantage substantially. Advantages derived from use of preferred provider arrangements to obtain discounts would also

[16] Significant controversy rages among economists concerning the proportions of any savings in employer health costs that would go to these three categories.

become less effective. On the other hand, advantages based on ability to manage the use of care would not be affected.

Patients would also pay less. Their payments for lower coinsurance would decline in rough proportion to payments by insurers -- 25 percent. Too little is known about their current balance billing payments (and what physicians and insurers will do) to determine whether they would decline as well.

**REFERENCES**

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